STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

MASTER BUILDERS ASSOCIATION OF KING AND SNOHOMISH COUNTIES and MASTER BUILDERS ASSOCIATION OF KING AND SNOHOMISH COUNTIES EMPLOYEE BENEFIT GROUP INSURANCE TRUST ("MBA TRUST")
No. 15-0062

CAMBIA HEALTH SOLUTIONS (RE MBA TRUST) ("CAMBIA 1")
No. 15-0071

BUILDING INDUSTRY ASSOCIATION OF WASHINGTON HEALTH INSURANCE TRUST ("BIAW TRUST")
No. 15-0075

CAMBIA HEALTH SOLUTIONS (RE BIAW TRUST) ("CAMBIA 2")
No. 15-0078

NORTHWEST MARINE TRADE ASSOCIATION and NORTHWEST MARINE TRADE ASSOCIATION HEALTH TRUST ("NMTA TRUST)
No. 15-0079

CAMBIA HEALTH SOLUTIONS (RE NMTA TRUST) ("CAMBIA 3")
No. 15-0084

Docket No. 15-0062; 15-0071; 15-0075; 15-0078; 15-0079; and 15-0084

DECLARATION OF MOLLY NOLLETTE

1. I am over the age of 18, and I make this declaration on the basis of first hand personal knowledge and am competent to testify to the matters set fourth herein.

2. I am employed by the State of Washington Office of the Insurance Commissioner ("OIC") as the deputy commissioner for the rates and forms division.

3. Attached hereto as Exhibit 1 is a true copy of an email I sent on October 15, 2014 to Douglas Pennington, Director of the Rate Review Division Oversight Group with the federal Center for Consumer Information and Insurance Oversight, a subdivision of the federal Department of Health and Human Services, asking for federal guidance on several of the legal questions relevant to this case and Mr. Pennington's email response dated October 16, 2014, providing such guidance.

4. I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed this 6th day of May, 2015 at Tumwater, Washington.

Molly Nollette

EXHIBIT 1

From: Pennington, Douglas A. (CMS/CCIIO)
To: Nollette, Molly (OIC); Mayhew, James A. (CMS/CCIIO)
Cc: Gellermann, AnnaLisa (OIC); Lee, Lichiou (OIC)
Subject: RE: large group rating factor questions -- associations
Date: Thursday, October 16, 2014 9:35:36 AM

Molly,

Jim and I have discussed and we agree with your concerns and have no edits to your questions.

In other words, we agree that it would appear to be inappropriate for a bona fide association to differentiate rating or premiums based on the underlying employers, but rather they should/could use general employee classifications to differentiate, which are allowed by an employer group under ERISA. Likewise, it would seem inappropriate to differentiate by member employer length in the association, as again, the association is supposed to be acting as a single employee benefits provider to multiple employers in a bona fide association and not as a sales/marketing channel to disparate employer purchasers and therefore it should act like a bona fide association.

Also, if small employers (under federal definitions) are included in the association, we would expect that Washington would apply the DOL standards of what constitutes a bona fide association and not the more liberal state standards that are codified in WA statutes.

Please let us know if you have any questions and thank you for reaching out to us and hopefully this was helpful to you.

Sincerely,
Doug Pennington, CIE, CFE
Director, Rate Review Division
Oversight Group - CCIIO/CMS/DHHS
douglas.pennington@cms.hhs.gov
www.healthcare.gov | www.cms.gov/cciio
410-786-1553 (office) | 202-641-4814 (bb)

From: Nollette, Molly (OIC) [mailto:MollyN@oic.wa.gov]
Sent: Wednesday, October 15, 2014 7:39 PM
To: Mayhew, James A. (CMS/CCIIO); Pennington, Douglas A. (CMS/CCIIO)
Cc: Gellermann, AnnaLisa (OIC); Lee, Lichiou (OIC)
Subject: large group rating factor questions -- associations

Hello Jim, Doug,

The WA OIC is reviewing a number of filings that have been submitted for association health plans. We would like your guidance and assistance as we work through the rate filings.

Exhibit 1

For the following scenarios, assume that the association qualifies as a large group for the purposes of purchasing insurance.

1. As we look at the rating factors, we are seeing factors that do not appear appropriate for Large Group. One example is a rating factor that is different for each member-employer (the individual employers who are members of the association) within the association; another example is a rating factor based upon the length of time the member-employer has been a member of the association. This is a draft of the objection we are planning to send. Do you have any comments or feedback?

   Pursuant to 26 CFR § 54.9802—1(d), please identify the bona fide employment-based classification upon which [*insert questionable rating factor here*] is based.
   Please provide how the "employer" (the association) uses the bona fide employment-based classification for purposes independent of qualifying for health coverage.
   Please provide how this classification is consistent with the "employer's" (the association's) usual business practice.
   Please include all relevant facts and circumstances.
   Attach a copy of the tri-department rule:
   http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=12473

2. For the objection above, we anticipate getting responses in which the argument is made that the "employer" for the purposes of 26 CFR § 54.9802 is not the association, but is the member-employer. We believe that is not correct. Can you confirm our understanding?

Thank you for considering these issues. Please let us know if you have any questions.

Molly Nollette
Deputy Insurance Commissioner
Rates & Forms Division
Washington State Office of the Insurance Commissioner
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DECLARATION OF JIM C. KEOGH

I, Jim C. Keogh, am over the age of eighteen years old. I make the following declaration based on first hand personal knowledge and am competent to testify to the facts set forth herein.

1. I am the Policy and Rules Manager for the Policy Division of the Office of the Insurance Commissioner (OIC). I have been in that position since November 20, 2013.

2. I have been with the OIC for seven years. Prior to my current position, I was an Economic Policy Analyst for the OIC.

3. I am the OIC staff person who has been primarily responsible for evaluating the data and information available to the OIC concerning association health plans. One of the key issues I have been tasked with analyzing is the reasons for the difference in the premiums charged for health plans sold to small employers in the small group market (small group health plans) versus health plans sold to small employers through associations (association health plans).

4. In 2010, concerns about the differences in the premiums charged by association health plans and small group health plans, and the effect this difference could have on the viability of the small group market, prompted the Washington State Legislature to order the Insurance Commissioner to study association health plans and small group health plans, and report back on his findings to the legislature. The Legislature through Engrossed Substitute House Bill 1714, ch. 172, Laws of 2010, authorized the Commissioner to conduct a data call of Washington authorized health insurance carriers who sold small group and association health plans.

5. The Commissioner contracted with Mathematica Policy Research group to conduct a review of the data collected in 2010. I worked closely with Mathematica during their initial analysis and during their update in 2011. Mathematica issued a report titled "Association Health Plans and Community Rated Small Group Health Insurance in Washington State" on September 30, 2011 (Mathematica Report). The Mathematica Report is

available in its entirety online at http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/association-health-plans.pdf.

6. Since the Mathematica report was issued, I have monitored and analyzed continuing trends in the association health plan market. As part of my review and analysis of this issue, I have reviewed health plan filings submitted by insurance carriers that have sold large group health plans to associations, the annual statements submitted by carriers, information submitted to the Insurance Commissioner pursuant to the Legislature's authorized data call, information in the Mathematica Report, and other information provided by carriers and associations about enrollment in association health plans since the Mathematica Report was issued.

7. My analysis and review of these association health plans led me to develop several charts to help OIC staff, and members of the public, better understand how association health plans differ from small group health plans, who purchases association health plans, the impact association health plan practices have on enrollees, and the impact association health plans have on the market in general. Those charts are attached to this declaration as Exhibit A.

8. Exhibit A, Chart 1, demonstrates the difference in the premiums between the oldest and youngest enrollees in small group health plans and association health plans. For small group health plans, premiums charged to the oldest enrollees cannot be more than 3.75 times the premiums charged to the youngest enrollee. The Affordable Care Act further restricted this difference in premiums between the oldest and youngest enrollees to 3.0 times the premiums charged to the youngest enrollees. However, for association health plans, older enrollees were charged as much as 8 times what the youngest enrollees in a plan were charged.

9. Exhibit A, Chart 2, demonstrates that even in a fairly narrow age span, ages 40-50, the difference in the premiums charged by association health plans is dramatic. In small group health plans, males who are 50 pay approximately 40% more than males who are 40.

But in association health plans, males who are 50 pay as much as 72% more than males who are 40.

10. Exhibit A, Chart 3, demonstrates that association health plans are less likely to insure anyone over the age of 50. Approximately 25% of the small group market is made up of enrollees over 50. But for association health plans, enrollees over 50 make up less than 20% of their demographic. This implies that employers with a significant number of employees over 50 are being priced out of the association health plan market.

11. Exhibit A, Chart 4, demonstrates that, particularly for women in child bearing years, association health plans charge significantly more for women than for men. This increased premium for women in childbearing years has no correlation in the small group market.

12. Exhibit A, Chart 5, demonstrates that within association health plans, different employers in different industries are charged significantly different premiums based simply on the kind of business the employer is engaged in. Charging different premiums to employers in different industries is not allowed in small group health plans.

13. Exhibit A, Chart 6, demonstrates that, within association health plans, the small employers enrolled are actually fairly large. In small group health plans the majority of enrollees, 52%, have employer sponsored coverage from employers with 2-10 employees. In association health plans, these employees of these small employers make up only 36.4% of enrollees. On the other hand, 33% of all association health plan enrollees are from employers with 26-50 employees.

14. Exhibit A, Chart 7, demonstrates that in fact, association health plans have maintained lower premiums than both small group health plans, and other large group health plans. However, as demonstrated by the previous 6 charts, these lower premiums are likely due to the fact that most association health plans offer the best rates to healthy males under 40,

in select professions, who are part of employers with 25-50 employees. Pulling this demographic of the healthiest employees out of the small group market likely forces higher premiums in the small group market as a whole. Exacerbating this problem, is the fact that association health plans charge employers with employees over 50, employees who are women of child bearing age, employers that engage in certain industries, and employers with the smallest number of employees, the more expensive premiums. The difference in premiums is likely forcing these employers with higher risk out of the association health plans, and into the small group market. This selection of the best risk, and rejection of the worst risk, likely accounts for the majority of the difference in the premiums between small group health plans, and association health plans.

15. If these trends are permitted to continue, it is likely that employers with the lowest risks will continue to be pulled from the small group market, and employers with the highest risks will continue to be forced back into the small group market.

SIGNED this 5th day of May, 2015 at Tumwater, Washington.

Jim C. Keogh
Policy and Rules Manager
Washington State Office of the Insurance Commissioner

EXHIBIT A

The Association Health Plan (AHP) Market in Washington state

Chart 1

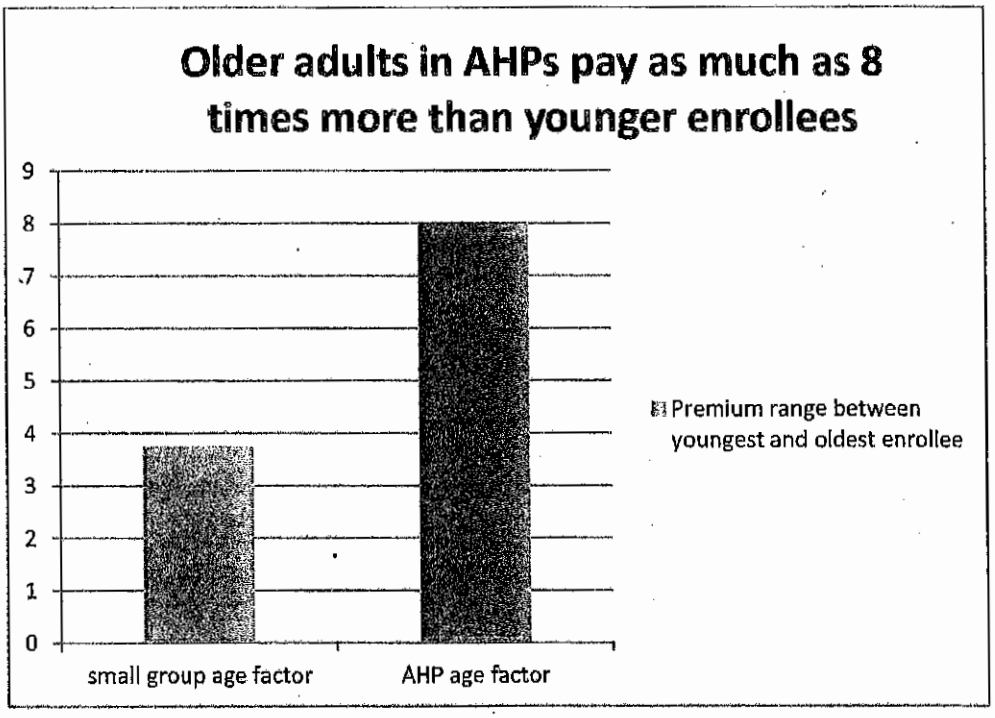

Chart 1 - Compares the range between the premium charged to the oldest and the youngest enrollee in both the small group market and a sample Association Health Plan (AHP). Under Washington state law, the premium for the oldest enrollee cannot be more than 3.7 times the youngest enrollee's premium, but in some association health plans, the difference can be as much as eight times the youngest enrollees' premium. *(Data from 2014 filings for 2015 use.)*

Chart 2

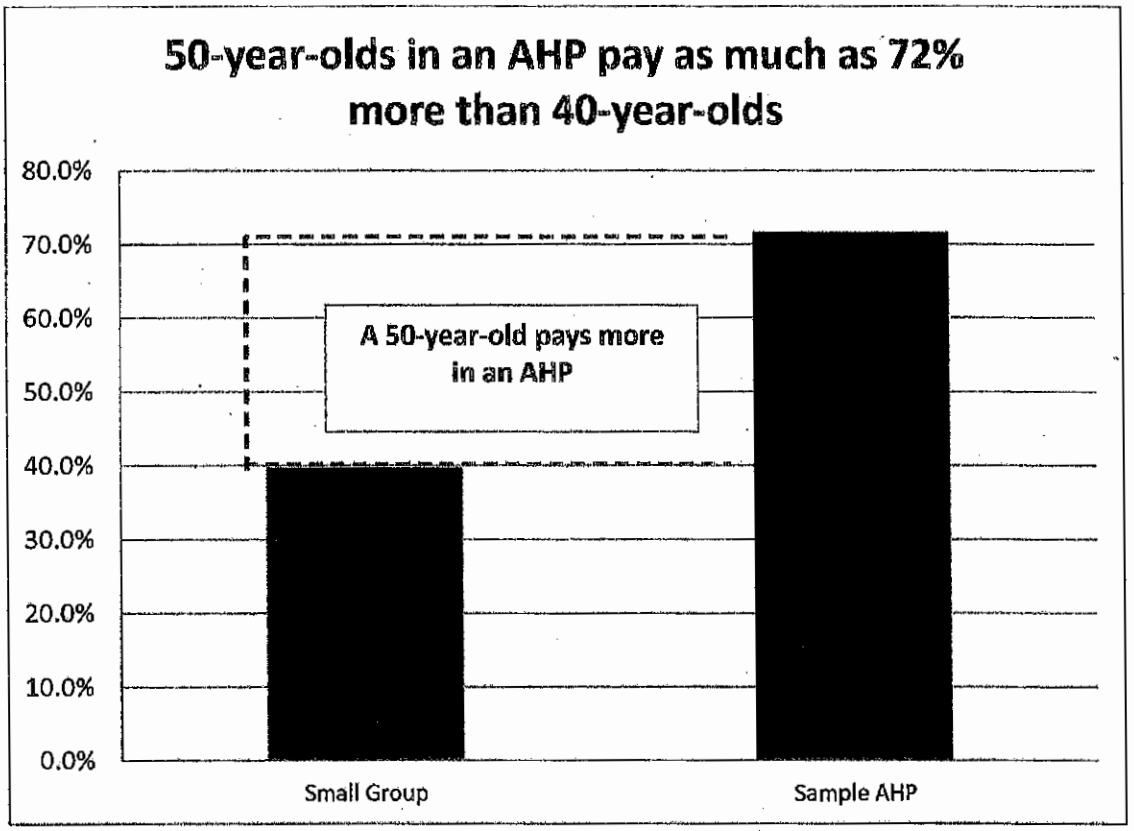

Chart 2 - Compares the percentage change in premium for males between age 40 and 50 for a small group plan and a sample Association Health Plan (AHP). In the sample small group plan, a 50-year-old pays 40 percent more than a 40-year-old, whereas in the sample AHP, a 50-year-old pays 72 percent more than a 40-year-old. *(Data from 2014 filings for 2015 use.)*

Chart 3

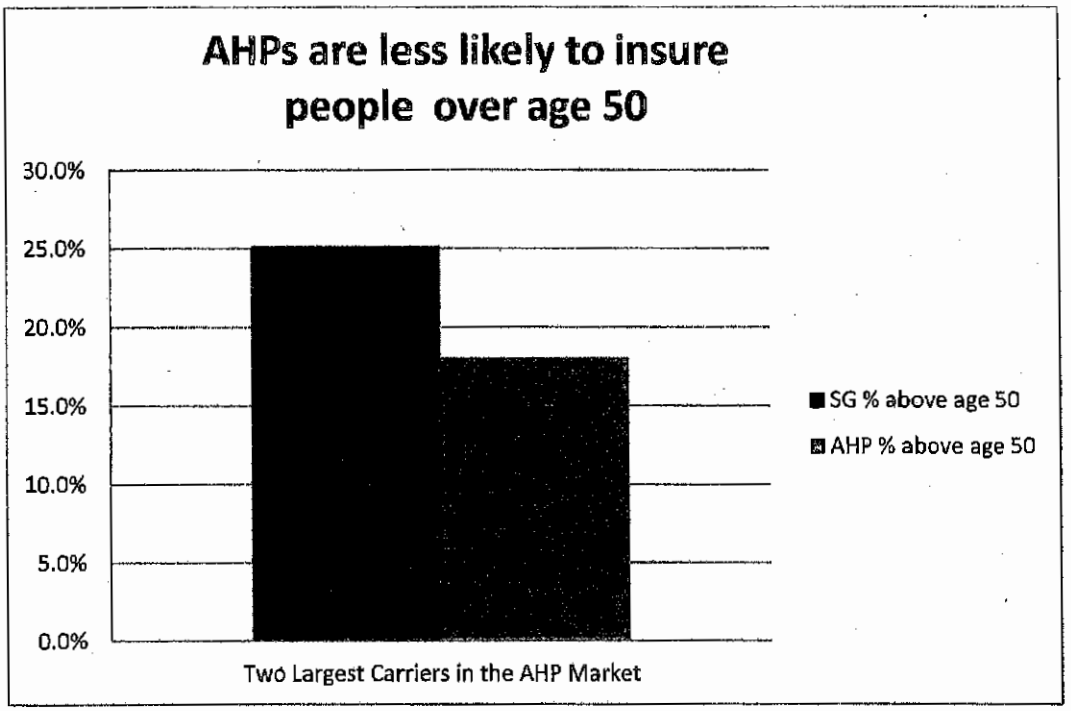

Chart 3 – Uses data from the 2011 Mathematica AHP study to reveal the decline in enrollment for individuals over 50 when compared to enrollment within the small group market. This implies that older individuals face steeper premiums in the AHP market than in the small group market.

Chart 4

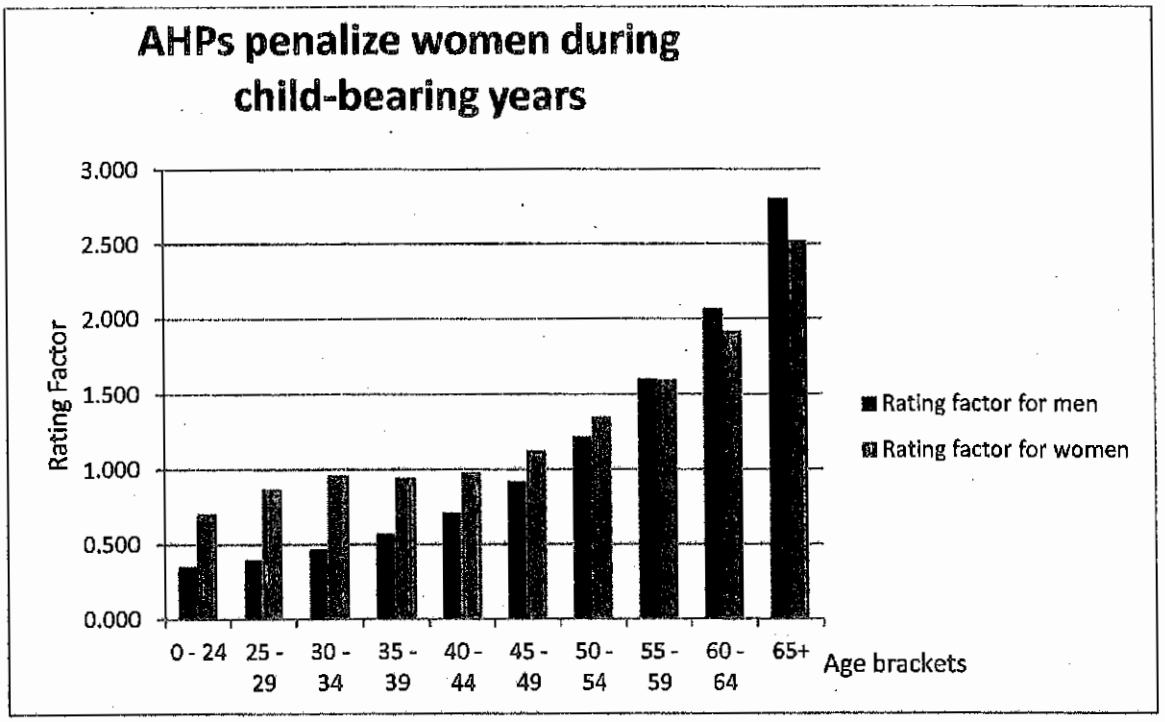

Chart 4 - Compares the rating factor for men and women by age group for a sample AHP. The graph reveals that a higher rating factor is placed on women during child-bearing years. *(Data from 2014 filings for 2015 use.)*

EXHIBIT A - 4

Chart 5

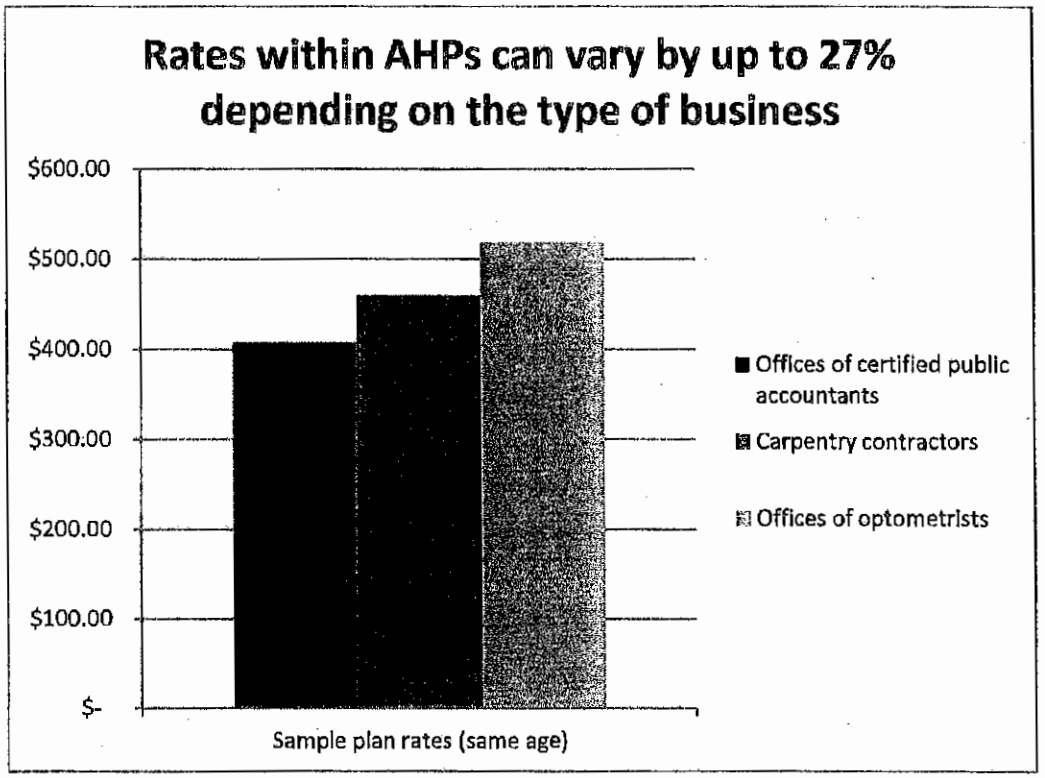

Chart 5 - Employers in different industries who get coverage through AHPs are typically assessed for health care coverage based on a specific industry factor (in addition to any differences by age or gender). The industry factors are not always based on the risk level of the occupation and may be estimated using experiential data. For this comparison, age and gender are held constant to show the impact of the industry factors. Different premiums for different industries are not allowed in the small group market. *(Data from 2014 filings for 2015 use.)*

Chart 6

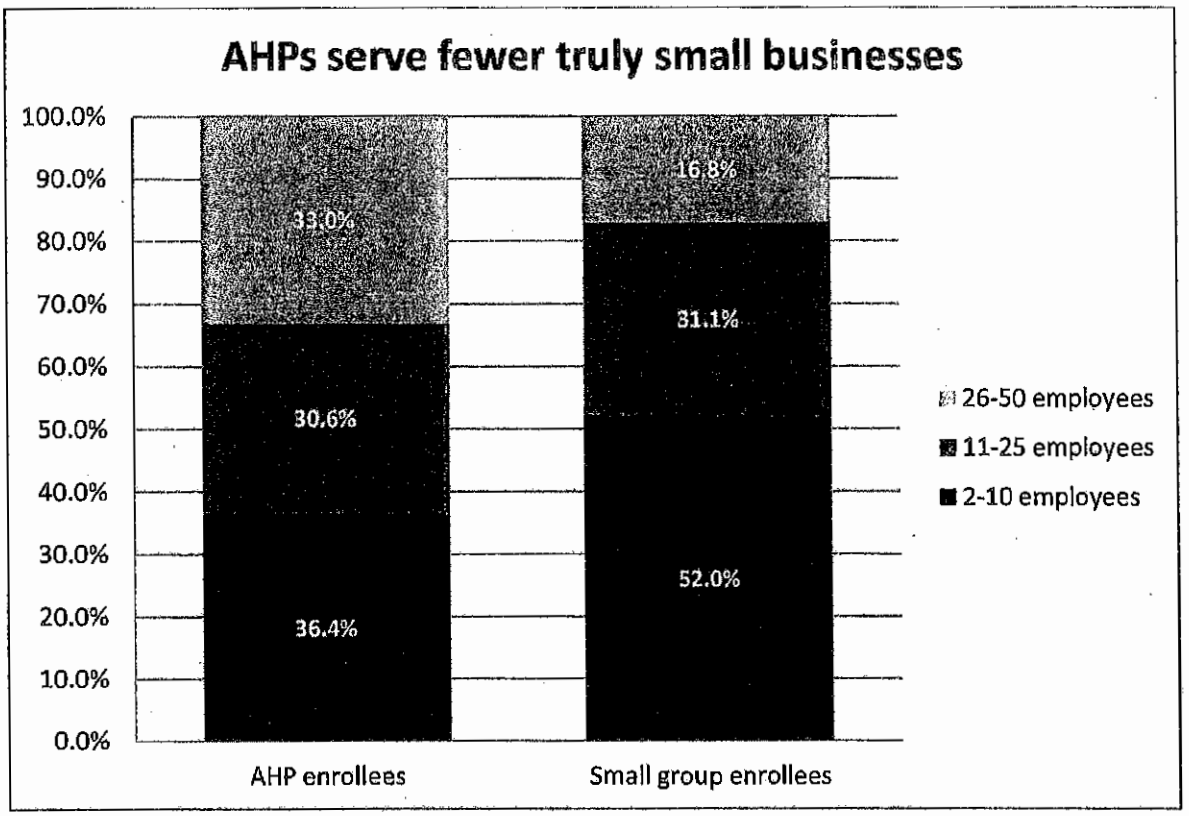

Chart 6 - Uses data from the 2011 Mathematica AHP study to show that small employers with two to 10 employees are underrepresented in AHP plans as compared to their proportion within the small group market.

Chart 7

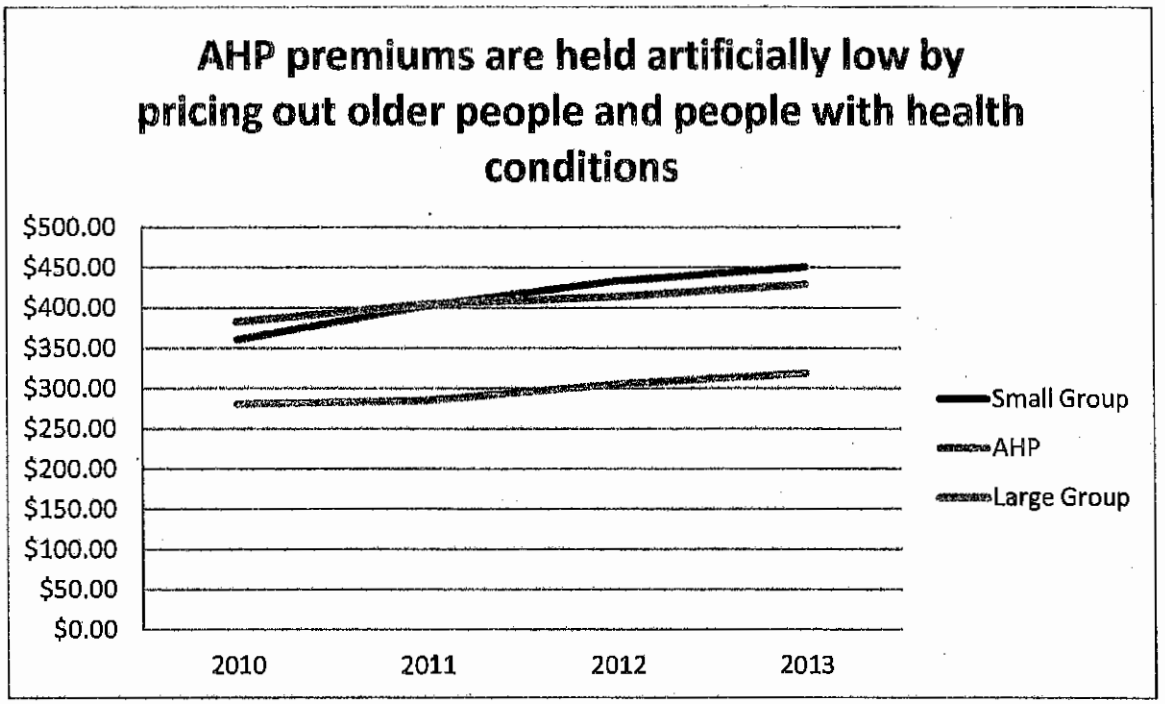

Chart 7 - Uses data from 2013 annual filings to show the average health premium per month by type of insurance coverage. The small group AHP market has average monthly premiums of $132 less per month than the small group market, implying that older individuals are priced out of the AHP market in order to keep overall premiums low.